
REFERENCE: WIC PROCEDURE MANUAL/ELECTRONIC MANUAL
http://apps.sd.gov/applications/ph01icds/ph01icdsnet/index.aspx

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CERTIFICATION

I. Eligibility Criteria

GOAL: To establish statewide uniform criteria for the determination of eligibility/ineligibility of potential participants based on income, nutritional risk and service area residency requirements.

A. Income Eligibility

Objective:

1. Utilize the ICDS Income form developed for the WIC Program for gathering data when making financial eligibility decisions. The Income form is part of the Certification and is completed for all applications.

   b. In 2003, the ICDS system was updated to print a blank income form to assist Local Agency staff with obtaining income information for new applicants. This worksheet allowed staff to enter the information on the computer. The blank income form matches the ICDS Income form.

2. Provide Local Agencies with policies and schedules of income eligibility based on the established level of 185 percent poverty. (See electronic manual Certification/Income Eligibility policy for income guidelines.)

Implementation:

1. All Local Agencies will use the 185 percent of Poverty Income guideline when determining income eligibility.

2. All Local Agencies will implement new income guidelines as rules allow.

Evaluation:

WIC income eligibility will be evaluated during Local Agency chart reviews during the management evaluation process.

B. Nutrition Risk Criteria

Objective:

1. To assure a method for implementation, monitoring and evaluation of the established set of national WIC nutrition risk criteria. In the determination of nutritional risk by all Local Agencies.

a. Nutrition Risk Criteria

1.) Background

In 1989, Congress mandated in Public Law 101-147 that USDA conduct a review of risk criteria and the priority system designed to ensure that WIC benefits are provided to those most in need of them in the event that funds are not available to serve all eligible program applicants. In 1993, USDA awarded a grant to the National Academy of Sciences' Institute of Medicine (IOM) to undertake a comprehensive independent review of most (but not all) of the nutrition risk criteria in use by WIC State Agencies at that time. In 1996, IOM released its report of this study: *"WIC Nutrition Risk Criteria". A Scientific Assessment*.

This report was widely distributed and discussed.

The National Association of WIC Directors and USDA established a collaborative partnership to address issues and recommendations of the IOM Report and to develop an action plan to achieve greater consistency among State agencies in the use and application of nutrition risk criteria. The joint workgroup developed three lists of nutrition risk criteria: those allowed; those not allowed; and those needing future review.

The new policies were implemented April 1, 1999, with revisions as needed thereafter.

2.) Implementation Procedures

South Dakota evaluated the criteria used in 1998 and determined changes necessary to fully implement the approved nutrition risk criteria. A list of risk criteria South Dakota allows was developed, to include: choosing certain criterion to allow and choosing to use different grouping, naming, renumbering, bundling or more restrictive criteria. We coordinated risk criteria with other Department of Health programs as much as possible such as case management of pregnant women and babies.

WIC participants who are certified based on a criterion that was not contained in the State's approved list but whose certification period extended beyond April 1, 1999, were not reassessed mid-certification, but continued to receive benefits to the end of their certification period.

The WIC Policy and Procedure Manuals were revised to correspond to the changes in the new nutrition risk criteria, including, but not limited to the following: eligibility and certification, client identification cards, document revisions, and computer changes.

3.) Funding

No additional funding was requested to implement the criteria. Activities were absorbed through the on-going WIC grant which includes training staff.

4.) Computer Changes

The current computer software was re-written from the current Fox Pro version to Visual Basic. As part of the re-write, the new nutrition risk criteria adopted was incorporated into the software.

5.) Nutrition Risk Criteria Policy Implementation Timeline

DATE	ACTION STEPS
June-October 1998	• Evaluated criteria presently in use to determine changes necessary to fully implement the approved nutrition risk criteria • Coordinated with other Department of Health programs as much as possible for similar risk criteria such as case management of pregnant women and babies
August 15, 1998	• Submitted timeframe and action steps to Denver with 1999 State Plan
October 1998	• Approval of State Plan by Denver
October	• Submitted listing of criteria South Dakota will use from the Allowed Criteria List to Denver Office • Included any alterations, such as renaming, renumbering, bundling and using more restrictive thresholds with cross-reference that links our classification system to the Allowed Criteria List
October-December 1998	• Made computer changes • Wrote policies with justifications to the State WIC Policy and Procedure Manual to include: allowable criteria, changes to client identification cards, and other documents requiring change • Solicited input/review by WIC Nutrition Education Computer Committee
January 1999	• Submitted policies to Denver for approval
January/February 1999 February 22-23, 1999	• Finalized policies • Trained Local WIC Agency Contact Persons on new

	nutrition risk criteria
March 17, 1999	• Conduct statewide training to health professional staff in the field on new nutrition risk criteria
April 1, 1999	• Implemented new nutrition risk criteria
October 26, 2000	• Trained Local WIC Agency Contact on updated nutrition risk criteria.
January 2001	• Updated nutrition risk criteria to comply with revision 4
May 2001	• Submitted updated nutrition risk criteria to comply with revision 5 to Denver for approval
August 1, 2001	• Implement updated nutrition risk criteria to comply with revision 5.
October 1, 2003	• Implement updated nutrition risk criteria to comply with Revision 6
August, 2005	• Submitted updated nutrition risk criteria to comply with revision 7 to Denver for approval
October 1, 2005	• Implement updated nutrition risk criteria to comply with Revision 7
October 1, 2007	• Implement updated nutrition risk criteria to comply with Revision 8

6.) Training

Local WIC Agency Contact persons were trained on the new nutrition risk criteria prior to all field staff. They were the person responsible to assure proper implementation in the field. All field staff were provided a mandatory training for full implementation. Follow-up training was done as appropriate. Currently risk criteria revision training is provided by the Training Coordinator and the Nutrition Staff providing updates and follow-up training during Regional or Local Agency Meetings.

7.) Evaluation:

1. At periodic Local WIC Agency Contact meetings, follow-up to implementation will be done to assure proper implementation. Local WIC Agency Contact persons will monitor nutritional risk determinations made by the Local WIC Agency when they are in agency.
2. Additional follow-up training to all field staff will be done as necessary.
3. Observations will be done for quality assurance as appropriate.
4. Nutrition risk eligibility determinations will be done during the Local WIC Agency Management Evaluation Reviews at each agency every 2 years through chart reviews, observations and office reviews.
5. Monthly field staff has opportunity to submit questions/issues to the State Office for answers/responses. The questions/issues and

State Office answers/responses are distributed to the field staff in a numbered memo and WIC Talks.

6. There are no longer Local WIC Agency Contacts in the Local Agency. Nutrition Staff are a part of the Local Agency.

Implementation:

Potential participants shall be determined to be at "nutritional risk" by a competent professional. Nutritional risk means: (a) Detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements; (b) Other documented nutritionally related medical conditions; (c) Dietary deficiencies that impair or endanger health; (d) Conditions that directly affect the nutritional health of a person, including alcoholism or drug abuse; or (e) Conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, including, but not limited to, homelessness and migrancy.

According to the Federal Regulations, Section 246.7 (d-3), a priority system "shall be applied by the competent professional authority when vacancies occur after a Local Agency has reached its maximum participation level, in order to assure that these persons at the greatest nutritional risk receive program benefits".

The following priority system for nutritional risk criteria has been established:

Priority I. All pregnant women, breastfeeding women and infants at nutritional risk as demonstrated by hematological or anthropometric measurements, or other documented nutritionally related medical conditions, which demonstrate the person's need for supplemental foods.

Priority II. Except those infants who quality for Priority I, infants (up to 6 months of age) born to women, who participated in the WIC Program during pregnancy or whose medical record documents that they were at nutritional risk during pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.

Priority III. Children at nutritional risk as demonstrated by hematological or anthropometric measurements or other documented medical conditions which demonstrates the person's need for supplemental foods. Postpartum women at highest nutritional risk because of age or whose medical condition documents them at nutritional risk.

Priority IV. Pregnant women, breastfeeding women and infants at nutritional risk because of dietary practices and postpartum women at risk because of substance abuse and certain medical reasons.

Priority V. Children at nutritional risk because of dietary practice or who are homeless or migrant.

Priority VI. Postpartum women, not breastfeeding, who are at nutritional risk for dietary reasons, or who are homeless or migrant.

Priority VII. Not currently used by South Dakota at this time. This priority can be used solely for homelessness and migrancy, however, South Dakota chose to place the participants in priorities 5 and 6.

Decisions on which priority categories will be served shall be based on funding levels. As funds become less, priority groups are eliminated, beginning with Priority VI.

The Priority System was revised to include high risk postpartum women at a higher priority than Priority VI.

Refer to Procedure Manual – Priority System/Nutrition Risk Section.

Evaluation:

During Local Agency chart reviews complete with the management evaluations the use of the priority system and nutritional risk determination will be reviewed.

C. Service Area Residency Requirements

Objective:

1. To develop criteria to provide Local Agencies guidance in determining residency requirements based on health services areas rather than county borders.

Implementation:

1. Local Agencies will determine potential participant health service residency requirements according to policies and procedures sent forth by the State WIC Office and in accordance with WIC Regulation Section 246.7(b)1. These areas may include more than one county and/or reservation. Applications must reside within the jurisdiction of the State of South Dakota.

Evaluation:

Participation shall be reviewed bi-annually during Local Agency monitoring/management evaluation visit.

II. Processing Standards for Certification

GOAL: To establish guidelines for Local Agencies regarding processing standards, which include creation of waiting lists, verification of identity, and residency notification requirements, scheduling appointments, certification periods, and transfer of certification.

A. Priority System/Waiting List

Objective:

To have all Local Agencies follow the established guidelines when accepting applications, determining eligibility/ineligibility, certifying participants, issuing food instruments or serving a prioritized waiting list.

Implementation:

1. All persons in the priority categories currently served who present themselves to the Local Agency during clinic hours to request program benefits will be handled in one of the following ways:

    a. They will be given a blank Income Form to fill out, upon which they will record their name, address, and income information. If they do not meet income and/or residence guidelines, they are immediately informed of their ineligibility and/or their right to a fair hearing. Their Income Form and the ineligibility notice will be kept in the ineligible file. If the applicant is financially and residentially eligible, the applicant goes through the certification process to determine nutritional risk.

        The processing standards used for all WIC applicants are:

        Special nutritional risk applicants must be notified of their eligibility/ineligibility within 10 calendar days of the first request for program benefits, with the exception of clinic sites open only two days per month. In those instances, the agency is allowed 15 days to notify special high risk applicants. Special high risk applicants are pregnant women, Priority I; infants under 6 months of age, Priority I, II, IV; and member of a migrant farm worker household. (A migrant farm worker is defined as an individual whose employment is on a seasonal basis in an agricultural field and established temporary residency.)

        All other potential participants meeting the financial and residential criteria must be notified of their eligibility within 20 calendar days of their first request for benefits.

        Food Instruments must be issued at the same time as notification of eligibility.

    b. The eligibility determination, nutritional risk assessment and food instrument issuance may all be accomplished at one time, provided the 10 and 20 day limits are adhered to as outlined above.

    c. The processing of an applicant begins when the applicant makes initial contact with the Local Agency during office hours to request benefits. The request for service may be made in person, over the phone or in writing.

Evaluation:

Review of the processing standards will be done at Local Agency monitoring/management evaluation visits.

B. Scheduling Appointments

Objective:

1. To have all Local Agencies follow established procedures when scheduling appointments for potential WIC applicants.

Implementation:

1. Local Agencies strive to have all certification appointments available within 10 calendar days for all applicants.

2. Local Agencies must make client service the top priority and serve emergency/hardship cases the day of initial contact or the next scheduled WIC clinic day.

3. Local Agencies need to consider adjustments in clinic scheduling to accommodate transportation problems, work schedules, minimal time away from work, and other difficulties that may prevent potential applicants/participants from scheduling/keeping an appointment. The agency is encouraged to consider flexible clinic scheduling to include appointments during evening, early morning, or lunch hour to do this.

4. Local Agencies work with their respective Regional Manager/Nurse Consultant in special situations to be flexible and accommodating to participants, cultural differences, hardships, and so forth, at the same time work within to maintain clinic organization.

Evaluation:

Review of the Local Agency scheduling records will be done during monitoring/management evaluation visits.

C. Transfer of Participants

Objective:

To have all Local Agencies follow established procedures for participants who transfer from one program to another.

Implementation:

1. A Transfer VOC (Verification of Certification) document or computer transfer will be issued by the Local Agency to participants who intend to relocate and will be accepted by the agency to which the participant is moving to as a verification of certification. The South Dakota Transfer VOC will be issued to migrant farm workers and to other transferring participants.

   Transferring participants are serviced according to:

   a. Any participant transferring from out-of-state, certified for a priority category not currently being served by the South Dakota WIC Program, will have their name placed at the top of the waiting list

ahead of all other participants to be served when funding becomes available.

b. Any participant transferring from a program within the State of South Dakota or within their own Local Agency certified for a priority category not currently being served by the South Dakota WIC Program, will have their name placed at the top of the waiting list ahead of all other participants to be served when funding becomes available.

Evaluation:

Review of policies and procedures will be done during a monitoring/management evaluation visit.

D. Plans for Offering Program Benefits to Eligible American Indian and Migrant Farm worker Households -- Refer to Affirmative Action Plan.

DUAL PARTICIPATION

GOAL: The detection and prevention of dual participation. The State Office will develop and maintain a system to detect simultaneous participation in two or more WIC Programs and prevention of such participation.

Implementation:

A. At certification interviews, all participants will be informed or reminded that it is illegal to simultaneously participate in more than one WIC Program, in more than one local agency, in more than one site of a single local agency, in a single agency or in WIC and CSFP during the same time period.

B. A complete certification must be done on those clients transferring to a WIC site without a current verification of certification document or other documentation of current certification.

C. If there is reason to believe that a client frequently travels between two WIC agency service areas, the local WIC office will contact the other WIC agency to check on client status.

D. When a participant is moving from one state to another or between ITO's and the State WIC Program – Local Agency staff ask the participant if they are currently on WIC somewhere else. If they indicate they are then the Local Agency contacts the most recent site the participant received services to determine if the participant is partaking in two programs at one time.

E. The State WIC Office will quarterly run a computerized listing of possible dual participants. If an individual is identified as possibly receiving benefits from two or more local agencies, the Local Agency is contacted to resolve the situation. The system program uses the following data elements in comparison:

Soundex by last name
Soundex by first name
Birth month and year
Social Security Number

F. Participants found participating in the SD State Agency Program and an Indian State Agency Program or surrounding State WIC Program in the South Dakota State Agency Program in more than one local agency, in more than one site of a single agency shall be disqualified from one of the Programs immediately. Where intentional fraud is involved, a participant may be disqualified from participation in both programs. Before a participant is disqualified, that participant shall be given full opportunity to appeal, according to the Program Misuse policy.

Written agreements to detect dual participation of participants are in place with the following Indian Tribal Organizations and State Agencies:

Cheyenne River WIC Program
Iowa WIC Program
Minnesota WIC Program
Montana WIC Program

Nebraska WIC Program
North Dakota WIC Program
Oglala Sioux Tribe Commodity Supplemental Feeding Program, Pine Ridge
Omaha Nation WIC Program
Rosebud WIC Program
Standing Rock WIC Program
Santee Sioux Nation WIC Program
Wyoming WIC Program

Refer to Agreements in electronic manual for copies of current agreements.

FAIR HEARINGS/ADMINISTRATIVE APPEALS

GOAL: Procedures for the Fair Hearings/Administrative Appeals in accordance with Federal Regulations and the South Dakota Codified Laws.

I. Participant Fair Hearing Request

Objective:

To provide the mechanism for potential/actual participant to appeal adverse decisions regarding their eligibility/ineligibility for program benefits.

Implementation:

A. State Agency responsibilities:

1. Provide orientation training sessions for Local Agency personnel to include a discussion of the entire participant fair hearing procedure.

2. Distribute to each Local Agency as part of initial issuance of WIC forms, posters outlining the steps to request a fair hearing.

3. Conduct a fair hearing and provide a hearing officer as deemed necessary.

4. Upon request for a fair hearing notify the Local Agency whether to continue benefits or not.

B. Local Agency responsibilities:

1. Prominently display the Fair Hearing Poster.

2. Inform each applicant/participant of their right to a fair hearing in writing at each certification (Participant Agreement).

3. Notify applicants who are: pregnant, under 6 months of age or members of migrant farm workers households, determined to be ineligible, in writing, of the reason for ineligibility and the right to a fair hearing, within 10 calendar days of the initial visit. 15 calendar days from the initial visit if the clinic site is open only two (2) clinic days per month. All other applicants must be notified within 20 days from the initial visit.

4. Notify participants found ineligible at any time during a certification period, in writing, with a copy of their file, 15 days prior to termination of program benefits, of their ineligibility and of the right to a fair hearing.

5. Notify each participant at least 15 days before the expiration of each certification period, that the eligibility for the program is about to expire.

6. Continue to provide program benefits to those participants who appeal termination of benefits within the 15-day advance adverse notice period. Applicants who are denied benefits at initial certification or because of the expiration of their certification may appeal the denial but shall not receive benefits while awaiting the hearing.

7. Notify participants being cited for participant misuse of the following: details of the misuse, policies of the program and corrective action to be taken, their right to a fair hearing and provide a copy of the Fair Hearing procedures.

Evaluation:

Accomplishment of objective.

II. Local Agency/Food Retailer Administrative Appeal

Objective:

To provide the mechanism for Local Agencies and Food Retailers to appeal adverse decisions on the part of the State Office or a Local Agency.

Implementation:

The State Office shall inform Retailers and Local Agencies, in writing, of their right to a fair hearing in the event of denial of application or termination of participation or disqualified from participation.

Evaluation:

Accomplishment of objective.

FAIR HEARING SEQUENCE

The participant/applicant has 60 days from the date the Local Agency gives notice to deny, reduce, or terminate benefits or to pursue a claim for improperly issued benefits, to request a Fair Hearing. Upon request for a Fair Hearing, the participant/applicant will be provided a copy of the Fair Hearing Complaint form to complete and a written copy of the Fair Hearing procedure. A hearing must be held within three weeks of the time the State Office receives the hearing request. At least 10 days advance written notice shall be given the individual specifying the time and place of the hearing.

The hearing is conducted informally according to the rules of civil procedures. It begins with a formal statement by the hearing officer which identifies the hearing. The hearing officer then requests those persons representing each party to identify themselves for the record by stating their name, who they represent and their address. Only one person represents each party, but each may call witnesses.

The program representative then presents his opening statement. This statement usually consists of a short commentary or summary of the decision and action of the program against which the applicant has filed an appeal, the reason for the decision or action, and the overall approach the program will take to substantiate the appropriateness of the decision or action. Also included should be citations of the law, rule or policy used as the basis for the decision to take the negative action.

It is particularly important to include in the opening statement that the issue is the decision and the basis for that decision, not actions that occurred subsequent to the time of the decision. This helps to avoid claims that the current circumstances are better than they were when the decision was made. Anything that occurred subsequent to that date cannot be adequately assessed, and should not be a part of the hearing.

The applicant, or his representative, is then asked to make a short opening statement giving the applicant's position regarding the action which is being taken, the reason for this position, and the general approach he/she will take to substantiate the appropriateness of this position. The applicant may choose not to make a statement at this time, but to defer such a statement to the beginning of the presentation of his/her case.

The representative of the program is then called upon to provide evidence in support of the decision to take the negative action. At this time, exhibits, including medical documents, may be placed in evidence. The party not introducing the exhibit is given an opportunity to review it and to ask questions. Such questions should pertain only to the document itself. The hearing officer then determines whether the document is received in evidence or rejected and why.

Reports to be used as evidence must have been made available to the applicant prior to the hearing. Witnesses may be called by the program to give verbal testimony. Before giving testimony, the witness should state his or her name, and interest in this proceeding, for the record. The applicant, or his representative, may cross-examine any witness at the conclusion of their testimony. Questioning from the representatives of both sides made continue to the point of reason. Any witness may be recalled at a later time by either party when reasonable grounds to do so are present.

The hearing officer may ask questions of any witness to assist in understanding the case. This is usually done at the conclusion of all questioning of a specific witness. If the applicant represents himself, some assistance may be given by the hearing officer. However, the hearing officer does not present or argue either side of the case. An attempt is usually made to limit all

arguments and evidence to relevant points. If the hearing is especially long, periodic recesses may be granted or offered.

Upon completion of the presentation of the program's case, the applicant, or his/her representative is asked to present their case following the same procedures and limitations as the programs. In addition, the applicant, or his representative may wish to present rebuttal evidence and testimony relating to the program's presentation. The program's representative is then also given an opportunity to present rebuttal evidence. Such evidence is restricted to those points made by the applicant or his representative during his presentation.

Upon the completion of all rebuttals, the representative of the program presents a brief closing statement summarizing the basis for the program's decision to take negative action and the evidence gathered to support that decision.

The applicant or his representative then follows with his/her closing statement summarizing the applicant's position in opposition to the decision to take negative action and the evidence to support that decision.

Finally, the hearing officer terminates the hearing with a statement which concludes the hearing and notifies both parties that each will be mailed a copy of his decision within the specified time frame.

A decision, either supportive of the negative action or a reversal of it, will be issued in writing within 45 days of the request of the hearing. If the decision of the hearing officer upholds the decision to take negative action, the action becomes effective.

If the applicant does not appear, without good cause, for the hearing, the hearing will be considered abandoned and the decision of the program becomes effective.

The State may deny a hearing to an applicant who has been previously determined ineligible in hearing and cannot provide additional evidence. Refer to electronic manual Fair Hearing Process policies.

ADMINISTRATIVE APPEAL PROCEDURE

Food Retailers participating in the South Dakota WIC Program are entitled to administrative appeal rights. A food Retailer who is denied, suspended or disqualified from participation in the South Dakota WIC Program, has the right to an administrative appeal. Notification of the right to an administrative appeal is the responsibility of the State Office. The administrative appeal procedure established by the State will be utilized.

The WIC Program shall inform all food retailers and Local Agencies of their right to an administrative appeal when any adverse action (disqualification, application denial) affects their participation in the Program. Appealing an action does not relieve the Local Agency or food retailer permitted to continue in the Program while its appeal is in process, from the responsibility of continued compliance with the terms of any written agreement or contract with the State WIC Program.

1. Each potential WIC Retailer/Local Agency shall be informed of their right to an administrative appeal before entering into contract with the program. The right of appeal shall be granted when a WIC Retailer/Local Agency's application to participate is denied or, during the course of the contract or agreement, when a Retailer/Local Agency is disqualified or any other adverse action which affects participation is taken.

2. The State Agency shall provide a Retailer with 15 days and Local Agencies with 60 days advance written notice of contract or agreement expiration. Expiration of a contract/agreement with a Retailer or Local Agency shall not be subject to appeal.

3. The decision of potential disqualification from the program will be made by the State based on recommendations from the Local Agency, participants or other individuals connected with the program.

4. Written notification of the pending disqualification from the program, the causes for, and the effective date of action must be sent by certified mail to the Retailer not less than 15 days in advance of the action date, along with explanation of the appeal process. For Local Agencies, the written notice must indicate two effective dates for disqualification; one if the Local Agency chooses not to appeal and another if the Local Agency decides to appeal. For Local Agencies who choose not to appeal, the effective date of disqualification shall immediately follow the advance notification period.

5. A request for hearing by the Retailer/Local Agency must be submitted in writing within 30 days from notice of the adverse action. The request must identify the individual representing the Retailer/Local Agency and the decision being appealed.

6. Local Agencies shall be allowed to continue participation in the Program during the administrative appeal process.

7. Retailers shall not be allowed to continue participation in the Program during the administrative appeal process. To determine if a postponement of the disqualification is warranted, consideration will be made whether participants would be unduly inconvenienced and may consider other relevant criteria.

8. Within three weeks from the date of receipt of request, a hearing will be held. At least 10 days advance written notice will be given to the individual, specifying the time and place of the hearing.

9. In the event that the Retailer/Local Agency is unable to appear at the hearing on the scheduled date, the Retailer/Local Agency may request that the hearing be rescheduled. The hearing may be rescheduled only once.

10. The Retailer/Local Agency may be assisted or represented by an attorney or other persons as they desire.

11. All documents and records supporting the decision under appeal shall be available to the individual to examine prior to, and during the hearing.

12. The Secretary of Health, or his/or her designate, shall be the official Hearing Officer.

13. At the hearing, the individual shall be given an opportunity to present oral or documentary evidence and argument supporting his/or her position, as well as to question or refute any testimony or other evidence and to confront and cross examine any adverse witnesses.

14. The decision of the Hearing Office shall be based on the oral and documentary evidence presented at the hearing and such decision shall be made a part of the hearing record.

15. The individual and any designated representative shall be notified in writing of the decision of the Hearing Official within 60 days from the date of the request for hearing by the State Office.

16. When the decision of the State is upheld, the effective date of disqualification shall immediately follow the Retailer's/Local Agency's receipt of notification.

17. A written record shall be prepared with respect to the hearing, which shall include the decision under appeal, any documentary evidence admitted, and the summary of any oral testimony presented at the hearing, the decision of the Hearing Official and a copy of the notification to the individual concerning the decision.

18. The written record of the hearing shall be preserved for a period of three years and shall be available for examination by the person or his/or her representative at any reasonable time during this period.

19. If the appellant expresses an interest in pursuing a higher review of the decision, the State Office will explain any available state level rehearing process.

20. Beyond this, any further appeal shall be treated as a contested case with right of review pursuant to SDCL 1-26-21.1.

21. Refer to electronic manual Administrative Appeal Process.

COORDINATION/COLLABORATION EFFORTS

SOUTH DAKOTA DEPARTMENT OF HEALTH INFANT IMMUNIZATION INITIATIVE

BACKGROUND

Rapid City, South Dakota was chosen as one of six project sites funded by the Centers for Disease Control to address immunization concerns as a result of multiple outbreaks of vaccine preventable diseases in the United States in recent years.

An Infant Immunization Initiative Plan (I-3) was developed for the entire state of South Dakota which included collaboration and linkages with health care agencies/providers.

On November 13, 1991, South Dakota Secretary of Health, Barbara Smith and Governor George Mickelson presented the Rapid City/South Dakota Infant Immunization Initiative Plan to Assistant Health and Human Services Secretary James Mason, Surgeon General Antonia Novella and Centers for Disease Control Director William Roper. The day was a success and attention from the press aided in starting I-3 activities off with a bang!

EXECUTIVE SUMMARY OF RAPID CITY AREA/SOUTH DAKOTA INFANT IMMUNIZATION INITIATIVE PLAN

The Infant Immunization Initiative (I-3) plan for Rapid City Area/South Dakota lays the groundwork for implementing uniform immunization practices and present innovative actions toward achieving the goal of 90 percent immunization coverage levels for two-year old children by the year 2000. The Rapid City Area/South Dakota I-3 Plan concentrates on the removal of barriers which impede vaccine delivery and the elimination of missed opportunities to vaccinate and educate during office or clinic visits and other encounters with health and social services. The Rapid City Area/South Dakota I-3 Plan outlines a variety of strategies to improve immunization coverage levels, including collaboration with local health clinics and other service provider an increase in levels of service capacity, and linkages with local health care providers and social service agencies.

The Rapid City Area/South Dakota I-3 Plan addresses the barriers to immunization that South Dakota's children most often experience and presents new and innovative ways to overcome them. Included are specific objectives to improve service delivery, to implement effective assessment tools and to educate and inform health care providers and the public about childhood immunizations.

The Department of Social Services has made a major commitment to the success of the Plan. In coordination with Community Health Nursing, it will expand immunization to include AFDC/public assistance intake sites and Food Stamp issuance sites. The department is also going to increase reimbursement for immunizations to Medicaid providers. Immunization education materials will be developed in quantities sufficient to reach all social services program recipients and applicants.

The Division of Health Services, with support from USDA, is taking a big step toward increasing immunization levels of its recipients by proposing a combination of WIC and immunization services with the help of nurse outreach workers and a project coordinator. This project will eliminate numerous barriers to immunization by providing services at WIC certification and voucher sites.

The Division of Public Health, in cooperation with Indian Health Services, is committed to the formation of coalition with the United Sioux Tribes Aberdeen Area Health Board. The purpose

will be to address and overcome immunization barriers in our largest minority population, Native Americans.

The efforts of the Department of Health and the state's immunization providers will be combined to implement a proposed vaccine delivery system in hospital emergency rooms, to establish uniform service delivery standards in accordance with CDC's "Standards for Immunization Policy and Practice" and to carry out in-service training for health care providers, both public and private.

The Dakota Association of Community Health Centers is committed to making immunizations more user friendly by offering "express lane" immunization services and expanded clinic hours in certain locations. The Rapid City Parent Child Center will require age-appropriate immunization of its enrollees.

The Division of Public Health will conduct two-year-old immunization level surveys in the Rapid City area and develop other assessment tools to measure progress towards the I-3 Plan's objectives. The immunization level surveys will be useful to target areas with especially low levels which may require special attention. In addition, assessment tools will be developed to evaluate the performance of individual providers by analyzing their vaccine usage. Measurement tools such as these will ensure that "what gets measured gets done".

Many of the I-3 Plan's objectives will be met through changes in policies or interagency collaboration. Many of the actions presented will be implemented during FY92 with current staffing levels and resources. Other proposals in the Plan will require additional planning or resources, including new FTE and funding. In summary, the Rapid City Area/South Dakota I-3 Plan represents a systematic change in the delivery of immunization services developed to attain the goal of 90 percent immunization coverage for two-year-old children.

OBJECTIVES IN PLAN SPECIFIC TO DIVISION OF HEALTH SERVICES AND WIC PROGRAM

Objectives written in the Plan with the Division of Health Services as lead agency area:

1. By July 1992, develop and implement an information and education plan to promote age appropriate immunizations at the community level.

2. By July 1992, establish community based organizations that will work cooperatively and collectively to eliminate barriers to immunizations in their respective communities.

3. By October 1992, improve availability of immunizations of children under the age of two who are WIC recipients.

4. By December 1993, provide education to persons/agencies that provide care to children.

PROGRESS TO DATE

Division of Health Services established a workgroup consisting of upper management and field staff (managers in field operations, supervisors, community health nurses from large and small county offices, nutritionist, and education specialist). The group identified tasks to fulfill the plan and the responsible persons and timeframes. Activities of the workgroup are: developing guidelines/tools for field staff to determine the where, when and how to assess immunization status; developing a tool to survey parents regarding barriers to immunizations; developing guidelines for community groups to assess barriers to immunizations and develop plan of action; developing educational and informational materials to promote age-appropriate

immunizations. Additionally, several workshops were held that featured an I-3 overview provided by the Communicable Disease Program.

The WIC Program at the Rapid City worksite began integration of immunizations in the WIC clinics in January 1992. Initiatives involved evaluating children's immunization records and making referrals for immunization where needed. Parents are asked to bring their children's immunization record to WIC clinic where a nurse checks for immunizations needed. WIC "voucher pouches" and recertification notices are stamped that immunizations are due. Immunizations are given on WIC certification day if the immunization either on WIC voucher pick-up day onsite or for an immunization appointment at a later dates. Beginning in March 1992, walk-in immunization clinics are available on every WIC voucher pick-up day.

WIC Agencies statewide have been notified of Rapid City's initiatives to also implement measures to improve the immunization status of children in conjunction with WIC.

WIC administered an annual participant survey in February which included a question on "one-stop shopping". The information from this survey should provide some insight on needs from the consumer point of view as to health services on WIC clinic days.

The WIC Program received WIC discretionary monies designated for coordination of immunization services with the WIC Program. Three FTE's received legislative approval in June 1992 in the Division of Health Services: one Outreach Worker to give immunizations on same day as WIC clinics, one WIC/Immunization Project Coordinator to overall coordinate immunizations into the WIC Program statewide and one clerical person to provide support services to the project such as flagging WIC charts when immunizations are not age appropriate, notify WIC participants of insufficient immunization records, assisting WIC participants in obtaining immunizations on WIC day.

WIC/IMMUNIZATION LINKAGES

BACKGROUND AND IMPLEMENTATION

The South Dakota WIC Program developed a partnership with the Immunization Program as a result of the South Dakota Department of Health Infant Immunization Initiative. This partnership has been unique in representing rural based settings in developing innovative strategies to improve immunization access to a rural community. Since most of the WIC Clinics are co-located in the Community Health Services Offices where the Community Health Nurse can administer shots, the linkages between the Immunization Program and WIC seemed effortless. The Community Health Nurse is also the WIC certifier in many clinics.

A variety of methods have been implemented throughout the state to improve accessibility and overcome barriers to immunizations for WIC participants and to integrate immunizations into WIC clinics. Some of these have been the following: adjustments to clinic scheduling to accommodate transportation problems; work schedules and other difficulties that may prevent participants from receiving immunizations, offering immunizations on WIC certification days and/or voucher pick-up days; exercising flexibility in scheduling to accommodate offering WIC and immunizations at the same time; designing voucher pouches with space to remind participants if their immunes are due and appointments. WIC clinics which are not associated with a Community Health Service Office are encouraged to work with Indian Health Services and Community Health Centers in co-scheduling of immunizations on WIC days, referral or assignment of a nurse to give immunes. In the Alliance Sites, immunizations are also part of the contract services with co-scheduling of immunizations on WIC days or referral if necessary.

WIC clinics statewide currently request immunization records of all children and assess the immunization status at WIC certification. If “one-stop shopping” services are available on-site, immunes are offered/administered; if not, the parent/guardian is given the opportunity to make an appointment for immunizations or a referral is made to the participant’s medical provider. If no immunization record is available, parental recall is used to facilitate an opportunity for referral and alerted to secure the child record. The WIC record and the WIC ID pouch is stamped “Immunes Due Now” when a WIC participant is in need of immunization. When a WIC participant is in need of immunizations, WIC records are flagged to assess at the next WIC visit.

WIC clinics are also encouraged to collaborate with other public and private providers to consider co-scheduling immunizations on WIC days, to facilitate referrals, provide opportunity to receive immunizations “on-site” at WIC or assign a nurse to give immunes at WIC clinic.

The WIC Program has taken a step beyond referral to actual intervention, made possible by the current service delivery system, and continues to support this practical model in helping raise the immunization level of two year olds in the state and was given National USDA recognition toward this effort.

To continue this support, WIC is participating in the CDC/WIC linkage proposal. The current WIC linkage in South Dakota occurs at every WIC site in the state. This linkage was fostered by the Department of Health’s service delivery organization where most WIC clinic sites are located at the Community Health Services Offices. In cases where this co-location occurs, the Community Health Nurse and WIC nurses are actually the same person. This linkage consists of immunization assessment and referral, either to the program staff or to the private provider of the parent’s choice, for all WIC participants during each certification process. The Alliance Sites provide the immunizations on site for WIC participants.

WIC/CDC LINKAGE PROPOSAL

The minimal reporting requirements mandated by Congress through the National Immunization Program require action beyond the current WIC and Immunization linkage policy/procedure to ensure that the necessary process and outcome measures were collected and reported to the Center for Disease Control by the South Dakota Immunization Program.

Three WIC clinic sites were chosen to enhance the current WIC/Immunization efforts. Sites include: Sioux Falls Downtown WIC Clinic, Belle Fourche WIC Clinic, and Mitchell WIC Clinic. Enhanced activities for each of these clinic sites will include:

1. Assess immunization records at every certification.

2. Flag charts of immunization records assessed if not up-to-date and reassess at the next WIC visit.

3. Collect process and outcome measures as outlined in the South Dakota plan utilizing the Integrated Client Data System (ICDS) or manually be done.

4. Make nursing services available on-site where not available.

EVALUATION

1998 Evaluation:

In 1998, a study was done to examine the effect that WIC was having on the rate of age-appropriate immunizations in South Dakota, statewide as well as the three pilot sites. The study was conducted by the WIC Program in conjunction with the Immunization Program of infants ranging in age from newborn to twenty-four months old. The study included collecting and entering immunization data on WIC participants from several field offices onto an immunization analysis software program, Clinic Assessment Software Application (CASA). The study focused on the difference WIC is making in increasing age appropriate immunization levels in the state, identifying characteristics of WIC that lead to increased immunization levels of WIC participants, analyzing the effectiveness of data collected in a pilot study in three WIC clinic sites, and an exploration of other linkages between the program for increasing immunization levels. A reasonable conclusion was made that WIC is making a difference in increasing age appropriate immunization levels in the state.

The 1998 WIC/Immunization Linkage Study showed that:

- Of the immunization records received, 82.1% were up to date on their age appropriate immunizations.
- Study results showed that the WIC age appropriate rates were usually higher than the overall county immunization rate.
- These rates are conservative and had the potential to be much greater if all immunization records had been collected.
- Immunizations included in the study were given at WIC offices as well as other healthcare facilities such as IHS and private clinics. All deserve credit for these rates.

2000 Evaluation:

In 2000, again a study was done, one at the three pilot sites and one statewide.

Study of Pilot Sites

The pilot linkage study involved the Davison, Butte (Belle Fourche), and Minnehaha Downtown WIC sites. The sites were given an assessment of immunization records for all children under 24 months of age. Immunization histories of the children were entered into the South Dakota Immunization Information System (SDIIS). The sites were required to perform immunization assessments for children 24 months of age and under at WIC certification, WIC reapplications, and during follow-up of records that were flagged during certifications and reapplications. Immunizations were made available on site at the time of assessment, and reminder/referral mechanisms for those in need of immunizations or with incomplete or missing records were established.

For the purpose of the present study, a survey was sent to each of the three pilot sites, requesting information regarding assessment of immunization status, administration of immunizations, office hours, and use of SDIIS. In addition, a visit was conducted at each of the sites, where follow-up questions were asked. The results of the survey and follow-up questions were assessed to determine whether the pilot program was being adequately carried out where it was effective in improving immunization rates.

Statewide Study

To assess aspects of WIC that positively affect immunization rates, a survey was sent to all WIC sites in South Dakota. 100% of the sites responded, and the results were tabulated and used to assess what efforts were being made at local offices to administer age-appropriate immunizations. An assessment of immunization rates at each CHN office was run, and the results were compared to data received in the surveys. The goal was to see what practices at the local level had the greatest impact on immunizations and to identifying potential areas for improvement.

Conclusions of Pilot Study

The three sites chosen from the WIC/Immunization Linkage Pilot Study were Davison, Butte (Belle Fourche), and Minnehaha Downtown WIC offices. These three sites were required to step up their assessments and administrations of immunizations, relative to the normal requirements of a SD WIC office.

The rates of up to date immunizations are retrieved from the South Dakota Immunization Information System (SDIIS) show that the pilot study has been ineffective in improving age-appropriate immunizations. This may be due to several factors. It is possible that SDIIS is not being used appropriately. Immunization histories may not be entered; children may not be accurately recorded. While both Butte and Davison stated that they do these things, Minnehaha Downtown has expressed a concern that they do not have enough staff time to adequately record histories, etc. in SDIIS and that they tend to forget to change a participant to inactive status when they leave WIC.

In addition, the statewide survey showed that many WIC sites across South Dakota are performing the same duties required of the pilot sites, making it difficult to compare the success of the pilot sites with non-pilot sites. It is certainly commendable that other WIC sites across the state are taking such initiative.

Another potential reason for the lack of success is missed opportunities. At least one of the three sites performs immunizations only on WIC Certification days and only by appointment, in accordance with the requirements for the pilot study. Infants, however, require immunizations at 2, 4, and 6 months of age, a schedule that cannot be met when certifications occur only every 6

months. Also the pilot sites were required to flag charts when immunizations were not up to date. Minnehaha has stated that they do not flag charts. All three sites were required to send tally sheets recording all administered immunizations to the state office. All three sites have stopped sending the sheets in.

There is little justification for continuing the pilot study; however, it would be worthwhile to commend those sites that are putting forth extra effort to administer immunizations and to offer suggestions for continuing to do so to all sites.

Conclusions of Statewide Study

As the survey results show, most of the WIC sites across South Dakota are going above and beyond the call of duty in assessing and administering age-appropriate immunizations. All sites are required to give immunizations or refer children that are significantly delayed according to the Recommended Childhood Immunization Schedule (See A1). In addition, many sites are giving immunizations to all children. Nearly 60% are flagging charts for immunizations that are not up to date, and many are extending office hours to accommodate clients with difficult work schedules. These sites deserve much credit for their efforts.

A South Dakota Immunization Information System (SDIIS) assessment run on the CHN clinics showed that there is still a great deal of room for improvement. It is possible that some sites still are not using the system correctly. Perhaps immunization histories are not being entered, or children are not being placed on inactive status when they leave the area. Maybe there are missed opportunities being overlooked. It is important to consider several factors when analyzing this data. First, CHN immunization numbers include both WIC and non-WIC children. In addition, many WIC children get immunizations at other clinics (e.g., private clinics).

In trying to determine what WIC offices were doing to effectively improve immunization rates, the top eleven and bottom ten CHN sites with respect to immunization rates were separated, and survey results of the WIC sites in these locations were examined. The 11 CHN sites with the highest up to date immunization rates were Brookings, Clark, Douglas, Gregory, Hand, Jerauld, Moody, Perkins, Roberts, Sanborn, and Ziebach. Those with the lowest rates included Bennett, Butte (Newell), Deuel, Haakon, Harding, Minnehaha-Downtown, Minnehaha-Westside, Perkins (Lemmon), Pennington (Rapid City), and Stanley. WIC sites associated with CHN offices with the highest immunization rates gave immunizations immediately when the need was determined and gave them to walk-ins. They also offered immunizations during all office hours, WIC or otherwise. Presumably, this has helped to avoid missed opportunities due to unnecessary referrals, missed appointments, and delays. Some of those with the lowest rates stated that they only give immunizations at WIC certifications and/or by appointment. While some offices are understandably short on staff time, it is important to remember that certifications usually only occur every 6 months, but children and infants need immunizations at birth, 2 months, 4 months, 6 months, and 15-18 months of age. WIC participants may miss appointments, and it's helpful to administer immunizations while they are in the office, instead of making appointments or referrals.

Overall, WIC sites are working hard to administer age appropriate immunizations, but there is room for improvement. Sites that do not flag charts, have flexible hours, and immunize without appointments should consider doing so. SDIIS needs to be used for assessment and recording of immunizations. Immunization histories must be entered into SDIIS in order for assessment to be accurate, and children who leave the WIC site permanently need to be changed to inactive status on SDIIS at that site. With increased vigilance in these areas, WIC offices can help improve immunization rates even more.

Future Plans

As a result of the 2000 WIC Immunization Summer Intern study, as part of the Department of Health's priority and as part of the Governor's overall program to improve health and well-being of children in South Dakota, a strategy was established to continue the commitment South Dakota has to increasing childhood immunization rates. The goal is to increase the age-appropriate immunization rates for the 19-35 month age children by December 2001. It was felt one of the greatest opportunities to assure children are age-appropriately immunized in South Dakota was through access to this population through the WIC Program for assessment, administration (possible through the service delivery organization as mentioned in Strategy I) or referral. See attached Immunization Plan March 2001.

Immunization Plan
Community Health Services/Public Health Alliance
March 2001

South Dakota's ultimate goal for the immunization rate of children 19-35 months of age is 90%. Community Health Services/Public Health Alliance staff may encounter this age population through a variety of services delivered, but the largest number of encounters with this age group is the WIC Program.

Community Health Services/Public Health Alliance nursing and nutrition staff provide service delivery through the WIC Program to a population of infants and children ages 0-5 years of age. Access to this population provides CHS/PHA staff an opportunity to assess and administer/refer for immunizations. This activity can occur at each encounter including voucher pick up, certification, and secondary counseling.

CHS/PHA offices with access to SDIIS will utilize the system for assessment of immunization status, encoding of immunizations administered and immunization history, and a tracking/recall system. In sites where SDIIS is not available, another mechanism will be in place to assure appropriate immunization activities can occur.

The WIC Program has promoted the WIC/immunization linkage for several years. A WIC/Immune survey was completed during the summer of 2000 to assess how local sites were integrating the guidelines established by the WIC Program to improve the immunization status of the WIC population. The SDIIS system was utilized to assess the status of age appropriate immunizations of WIC children ages 19-35 months.

The results of the Immune/WIC survey reflect that CHS/PHA sites could show improvement in areas the WIC Program has outlined as activities that local agencies will do to improve accessibility, break down barriers for WIC participants to receive immunizations and to integrate immunizations into WIC clinics where possible.

To improve the WIC/Immune Linkage CHS/WIC sites are to:

1. Consider adjustments in clinic schedules to accommodate transportation problems, work schedules and other difficulties that may prevent participants from receiving immunizations.

2. Offer immunizations with certification, food instrument pick-up days and secondary counseling to be more accessible for participants.

3. Exercise flexibility with time, dates, etc. of WIC clinics to accommodate offering of WIC and immunizations at the same time.

4. Implement practices to meet special needs of the WIC participants; consider needs of rural participants, working families, migrant families, homeless families and Native Americans.

5. Request immunization records of all children; zero to four at the certification.

6. Review and assess immunization records for immunization status using the SDIIS tracking system to track delayed children as well as determining those children that are due for immunizations at the time of their WIC visit.

7. Offer and/or administer immunizations if immunizations are due or delayed to provide "one-stop shopping".

8. Provide an opportunity to make an appointment for immunizations or facilitate the opportunity for referral to the applicant's public or private provider if "one-stop shopping" services are not available.

9. Flag records when participants are due for immunizations.

10. Send reminders to clients informing them of needed immunizations.

Plan: The steps listed below will be implemented for a 9 month time period.

1. A memo will be sent to CHS and Alliance Staff emphasizing the importance of the Immunization/WIC Linkage and the use of the SDIIS for the assessment of immunization status and the recall of children for immunizations.

2. Nutrition staff will receiving training on the current immunization schedule for children and will assess records during secondary counseling or other encounters as appropriate.

3. Regional Managers/Nurse Consultant will analyze data from the WIC and Immunization Linkage Survey to assess if answers given on the survey are appropriate for that WIC agency. (Office location, access to SDIIS, staff discipline serving agency, adequate storage and equipment for the provision of immunizations on site would need to be factors considered when assessing appropriateness of answer.)

4. Regional Managers/Nurse Consultant will be provided with a grid for each county to assist in this assessment. The grid indicates how each agency responded to the question.

5. Regional Managers/Nurse Consultant will assist local staff in how to implement any needed changes at the local site as a result of the assessment.

6. Regional Managers/Nurse Consultant will summarize changes that will be implemented by the agency and send to CHS Assistant Director by March 31, 2001. These ill be reviewed by the CHS Director, CHS Assistant Director and ODP Director.

7. Each WIC only agency will complete a local guideline outlining how the agency will implement the 10 areas listed above. Other CHS/PHA sites will complete a local guidelines on how the agency will implement the above 10 areas for the WIC population and all other infants and children seen at CHS/PHA offices. Regional Managers will assure that this is completed and sties are implementing by May 10, 2001.

8. The guidelines will be reviewed by the Regional Manager/Nurse Consultant and approved or will work with the agency in areas that can be enhanced to improve immunization administration or referral.

9. Prior to June 30, 2001, the Regional Manager/Nurse Consultant and the local agency will evaluate the established guidelines to assure that implementation of the agency's guidelines has occurred.

10. Immunization Program personnel will continue to assist local CHS/PHA sites as needed with the SDIIS functions.

11. An immunization chart flag tool will be printed and made available to staff for use as a chart reminder of immunizations due.

12. Sites will utilize the SDIIS for assessment and recall for immunizations of infants and children seen at their agencies for all services. Regional Managers/Nurse Consultant will do an initial/ongoing assessment to assure that all sites are using the SDIIS appropriately for all children seen in the CHS/PHA offices.

13. Regional Managers/Nurse Consultant will provide a monthly update of the immunization priority in their monthly report to the CHS Director.

Evaluation:

1. A data entry and transmission report will be run on a monthly basis at the Central Office.

2. An assessment of the immunization levels of children 19-35 months of age will be completed via SDIIS in July and November of 2001. Rates will be compared to the November 2000 Clinic Assessment of Children 19-35 months of age.

3. It is anticipated that all sites will show an improvement in the immunization rate of this age group.

4. Any site not showing improvement of immunization levels of children will be assessed again to determine reasons, possible solutions and corrective actions required to correct the problem.

BREASTFEEDING COORDINATION

BACKGROUND

The South Dakota WIC Program has made a major commitment in time and financial resources in the past years to improve its efforts in the promotion and support of breastfeeding. Local Agency resources were purchased, including patient-education videos, breastfeeding educational models, flipcharts, reference books, breast models, teaching balloons and breastfeeding aids (manual pump, breast shields) to be used in teaching WIC participants. June 1999, a speaker was sponsored at the Public Health Conference to address problems and solutions concerning breastfeeding. A Breastfeeding Committee was formed to help plan and guide breastfeeding efforts in WIC and then expanded into coordination with other programs. In 1992, demonstration projects were established with five original Local WIC Agencies to pilot the purchase of manual breastpumps for WIC participants and loan electric breastpumps. The efforts generated increased interest and excitement in breastfeeding among staff and participants. Activities are now a collaborative effort with MCH also utilizing MCH funds.

PROGRESS TO DATE

Each year breastpumps were purchased for agencies until all agencies now offer a free manual breastpump to every WIC breastfeeding mother who needs one. The breastpump is the mothers' to keep. A supply of electric pumps is available to loan free of charge for any WIC breastfeeding mother who meets specified criteria. The pumps have been quite successful and have encouraged many mothers to begin and continue breastfeeding. Additional electric pumps have been purchased. South Dakota now has 300 electric breastpumps across the state.

Some of the WIC clinics have begun teaching breastfeeding classes for pregnant women. These sessions cover topics such as: benefits of breastfeeding, understanding breastfeeding, getting started, normal guidelines, potential problems and good nutrition while breastfeeding. The counties that have these classes have seen increases in breastfeeding rates. To further promote and support breastfeeding, WIC clinics no longer use educational pamphlets, posters, videos, and so forth that contain formula company logos. Any formula which is distributed by WIC is kept at low visibility.

In 1994, a breastfeeding section was added to the WIC Policy and Procedure Manual that continues to be updated and expanded to enhance breastfeeding support and promotion.

In addition, the Breastfeeding Committee took on an expanded role of membership as well as responsibility and became a coalition. It is now named the South Dakota Breastfeeding Coalition. Members now include Nutritionists, Lactation Consultants, Physicians, Nurses and representatives from DOH, Cooperative Extension Services, Healthy Start, ITO's, Head Start (Early Start), USD School of Medicine, Indian Health Services, South Dakota State University, and LaLeche League. The coalition is now an interest group of the South Dakota Nutrition Council, Inc. The chair of the Coalition is a Professor in Family Medicine at the USD School of Medicine. The WIC Breastfeeding Coordinator continues to be a member of the Coalition.

Individual commitments of WIC staff are obvious. Most have attended additional workshops to upgrade their knowledge of breastfeeding. All new employees who provide breastfeeding counseling/promotion are required to use the Breastfeeding self-study kit. Six brochures of a breastfeeding series have been combined into a "Breastfeeding is Best" booklet and distributed. A "Congratulation's Certificate" was developed and distributed. Each year a new breastfeeding promotion poster is distributed to all offices.

COLLABORATIVE EFFORTS

In 1993 the South Dakota Cooperative Extension Service received a Nutrition Initiative Grant in support of the Healthy People 2000's goal of increasing breastfeeding rates to coordinate efforts with the WIC Program. Coordination began with Extension Service, Rosebud Sioux Tribe WIC Program, Cheyenne River Sioux Tribe WIC Program and the South Dakota WIC Program. The decision was made to focus their grant to expand the incidence of breastfeeding among rural and reservation women. During the initial year, six counties were selected to participate in the grant. They were: Bennett, Buffalo, Corson, Day, Dewey, and Todd counties. Within each of these counties, a 5-hour breastfeeding workshop was conducted by a Lactation Consultant, the South Dakota EFNEP Coordinator, and Extension personnel. In addition to the training's, local health professionals including WIC, with an interest in breastfeeding were encouraged to form a community based network or coalition. The goal of the networks is to address the issue of increasing social acceptance of breastfeeding and create an awareness of the benefits of breastfeeding. Some of the counties have continued to keep the coalitions active and are addressing breastfeeding issues at the local level.

Four additional counties were added in 1994. Workshops were organized for local health professionals in Brule, Charles Mix, Lyman and Roberts counties. Coalitions were also formed in these areas. In 1995 and 1996, efforts were focused on training additional health professionals, resource development and employer support for breastfeeding. Additional trainings were held in Moody, Pennington and Hughes counties. The grant was completed and activities enrolled into the state coalition.

To celebrate World Breastfeeding Week, the South Dakota Breastfeeding Coalition (including WIC) joins together for a breastfeeding campaign, making a variety of ideas available in the state, including the Local WIC Agencies. The campaign is intended to promote and support breastfeeding in hopes that more persons are encouraged to breastfeed and for outreach for the WIC Program. As part of the Extension Initiative Grant, which ended in fall of 1996, promotional pamphlets and refrigerator magnets for business cards were developed and distributed to WIC Clinics. In 1994, buttons, with the inscription "Mother's Milk...Something Wonderful to Grow on" were supplied by MCH for staff to wear to promote breastfeeding; breastfeeding posters were distributed to local physician clinics, hospitals and local areas which lists a 1-800 number to call; a newsletter was sent to health professionals telling them of WIC's commitment to breastfeeding and what WIC offers; and staff have arranged television appearances in support of breastfeeding and outreach for WIC. In 1995 and 1996, a promotional poster with the new breastfeeding logo and toll-free number was produced jointly by WIC, Cooperative Extension Service, Healthy Start and the ITO's. A contest was held to come up with a South Dakota theme on the poster, "Breastfeeding, Make It Your Choice." A variety of other activities have been conducted statewide including the Governor of South Dakota proclaiming August World Breastfeeding Week five years in a row. Since 1997 a new poster was printed and sent to all Local Agencies as well as to members on the South Dakota Breastfeeding Coalition. Many of the Local Agencies also display photographs of participants who breastfeed or are breastfed. In 1999 Breastfeeding door hangers were ordered and distributed to pregnant and breastfeeding WIC clients during August. Each year a new breastfeeding poster is sent to the Local Agencies. In addition to the poster, a handout, a copy of the Governor's proclamation, a press release shell and ideas of ways to promote breastfeeding are distributed to the Local Agencies.

FY04-05 Breastfeeding Peer Counseling: South Dakota applied for and was awarded a grant to pilot a Breastfeeding Peer Counselor Program in 3 Local Agencies. The Local Agencies that were selected were: Beadle, Brookings and Butte – Belle Fourche. The State Breastfeeding Coordinator and the 3 Local Agency Breastfeeding Coordinators received training on how to use the Loving Support Through Peer Counseling Curriculum, The Breastfeeding Peer Counselors were trained in 2005 and began seeing participants in the fall of 2005.

3 Breastfeeding Peer Counselors were hired to pilot the program in 3 Local Agencies. The 3 Local Agency Breastfeeding Peer Counselors to the Train the Trainer in Denver to assist the Peer Counselors in delivering the counseling. All Policies and Procedures to implement the program have been developed and distributed to the Local Agencies and Peer Counselors. Training was provided on the Loving Support Peer Counseling Strategies. Loving Support provided 3 step counseling strategies to all Local Agency staff via Dakota Digital Network. Program Forms were provided for the peer counselors and Local Agency staff use. Office supplies were purchased for the peer counselors and distributed. Demonstration materials were purchased for peer counselors. Peer Counselors began provided services in September of 2005.

FY05-06 Breastfeeding Peer Counseling:
The pilot program in the 3 counties have finished the Loving Support Counseling modules and have been seeing clients. All three sites have shown improvement in both the 6 month and 12 month duration rates. We have added 2 additional local agencies for Peer Counselors in Davison and Yankton Counties. We continue to develop materials for the Peer Counselors, both for education and promotion of the Peer Counseling Program.

FY06-07 Breastfeeding Peer Counseling:
Two of the original pilot sites are still running which include Beadle/Huron and Butte/Belle Fourche Counties and Davison has been operating for approximately a year now. All of these counties have shown an increase in duration of breastfeeding and continue to see caseload increases. Recently we added another program in Shannon/Kyle, this site is located on the reservation. The Peer Counselor is currently being trained with Training to be finished up the week of November 5th, 2007.

FY07-08 Breastfeeding Peer Counseling:
Growing Up Together is the contract agency operating 4 breastfeeding peer counseling programs. Sites are located in Beadle/Huron, Butte/Belle Fourche, Davison/Mitchell and Shannon/Kyle. All peer counselors are providing services in the community. All sites are offering Breastfeeding Peer Counseling classes, one on one counseling and referral information. We are not able to determine if the duration rates for Kyle has increased yet, but the other 3 sites we have seen an increase in the ever breastfed, breastfed 6 months and breastfed one year.

FY08-09 Breastfeeding Peer Counseling:
Growing Up Together continues to be the contract agency administering the Breastfeeding Peer Counseling Program sites. We continue to have 4 sites: Beadle/Huron, Butte/Belle Fourche, Davison, and Shannon/Kyle. Currently we are serving in all sites a caseload of 200. Caseloads include Pregnant and Breastfeeding Women. Peer Counselors are providing services through Community Health Fairs, one-to-one counseling and group counseling. They are providing educational information and referral services to the participants. They are meeting monthly via conference calls for discussion and technical assistance. We are currently offering on Breastfeeding Peer Counseling support group for Spanish speaking in Huron. Data from PedNSS report indicates Everbreastfed rates have increased in the Huron, Belle Fourche and Mithchell areas. Breastfed at 6 months has increased in all 4 sites and Breastfed at 12 months increased in Huron, Mitchell and Kyle from year 2005 to 2006.

South Dakota was awarded the Nutrition and Physical Activity Grant to Prevent Obesity and Other Chronic Diseases from CDC. There is a breastfeeding component to this grant. We have participated in developing 2 breastfeeding handouts.

HEALTHY START INITIATIVE

BACKGROUND

The Healthy Start Project is a presidential initiative to reduce infant mortality through additional support for comprehensive service delivery in 15 high-risk communities. Through grants administered by the Health Resources and Services Administration, NHS, the communities develop innovative approaches to reducing infant mortality in their specific community. The Aberdeen Area Tribal Chairman Health Board was awarded one of the 15 grants.

The Aberdeen Area Tribal chairman's Health Board is comprised of individuals representing seventeen (17) tribal nations and two (2) Indian organizations in a four-state region, Iowa, Nebraska, North Dakota and South Dakota. South Dakota tribes involved in the Healthy Start Initiative include: Standing Rock, Cheyenne River, Sisseton-Wapheton, Flandreau-Santee, Lower Brule, Crow Creek, Rosebud, Oglala, Yankton and Rapid City Indian Health Board.

PROGRESS TO DATE

Each of the nineteen (19) tribal communities in the Aberdeen Area project has hired a community coordinator to work with the communities in completing their needs assessments, and developing and implementing plans. Each of the tribal communities has established a local consortium to function as an advisory group to the coordinator. A large statewide consortium has also been established to include representation from state agencies and other public and private agencies. The Maternal and Child Health Program Director and the Nutrition Services/WIC Program Director are members of the large consortia.

The large consortia met in January 1992 and in June 1992.

The large consortium has divided into respective state workgroups to discuss/coordinate in four main topic areas that were identified. These were in collaboration, data collection/evaluation, public information and alternative funding. Both the WIC and MCH Directors participated in the South Dakota workgroups which met in August 1992.

A site visit by Dr. James Mason, Assistant Secretary of the Department of Health and Human Services was made August 7, 1992 to the Winnebago Tribe of Nebraska, Yankton Sioux Tribe of South Dakota, and Rosebud Sioux Tribe of South Dakota. Both the WIC and MCH Director participated in the visit as a member of the large consortia.

INVOLVEMENT OF WIC PROGRAM

Each Local Agency has been notified of the Northern Plains Healthy Start Initiative and that community coordinators may contact them to participate in a needs assessment process or on a local consortia. Agencies have been encouraged to participate when/if requested and that their role would be: 1) provide information on services available to maternal and child health populace; 2) give input on needed services; 3) assist in planning to meet identified needs.

MCH COLLABORATION

BACKGROUND

The MCH and WIC Programs have an exemplary working relationship and are collaborating on several initiatives/special projects in providing and improving services for pregnant women, infants and children throughout the state. This collaboration seeks ways to improve the health status of common participants, provides an avenue for effective and efficient delivery of services, allows maximum utilization of staff and resources through co-locations of clinics and cross utilization of staff for both programs, avoids duplication of efforts, increases availability and accessibility of health services and integrates services for one-stop shopping for participants.

INITIATIVES

CASE MANAGEMENT OF PREGNANT WOMEN:

The South Dakota Community Health Nurses, who are also WIC certifiers, provide case management services to pregnant women in nearly every county in South Dakota. The goal of the case management program is to improve pregnancy outcomes and to reduce maternal, neonatal and infant mortality and morbidity in South Dakota.

Case management is defined as the provision of services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for pregnant women and infants; to assure access to quality prenatal, delivery and postpartum care. The nurse case managers assist recipients in accessing medical care and other appropriate services, promote optimal health during pregnancy and provide intense prenatal education to promote a positive pregnancy outcome. The case managers assist in coordinating care within the client's community to utilize those resources which are best suited to the client's needs.

Pregnant women seen in the Community Health Nurse's offices have a prenatal risk assessment completed; receive educational materials and appropriate referrals for other services. Clients determined to be at risk are offered case management/care coordination services. Because of the coalition and cross utilization of WIC and MCH staff and clinics, WIC appointments are made immediately for pregnant women who are not currently on the WIC Program.

Case management services are funded by Title V and through an administrative agreement between the Department of Health and Medicaid (Title XIX).

TITLE X FAMILY PLANNING

In Local Agencies providing Title X Family Planning Services, participant with positive pregnancy tests are referred for WIC services.

TITLE XIX COORDINATION/REFERRAL:

Division Directors of Health Services and Medical Services meet monthly to coordinate services with other staff involved as pertinent. Discussions have included outreach and marketing, referral mechanisms, coordination of services for common clients, such as one application form. An interagency agreement exists between the South Dakota Department of Health and Department of Social Services to assure that services provided between departments are consistent with the needs of recipients.

Referral is made from Title XIX to the Health Department, including WIC, of all individuals identified as potentially eligible clients for health services. Community Health Nurses, who are also WIC certifiers, refer all individuals potentially eligible for Title XIX benefits. Clients are instructed on the application process and are provided forms to be completed prior to their first contact. The staff follow-up with clients to ascertain if clients did apply, or if they need further assistance with the application process.

HOMELESS AND MIGRANT BENEFITS

GOAL: To assure uniform criteria is applied for determination of benefits to homeless persons and instream migrant farm workers and their families, Local Agencies will use the following guidelines when serving these individuals.

I. Eligibility Criteria

A. A homeless person is any individual who may be residing in a vehicle, park, hallway, doorstep, sidewalk, abandoned building, temporary shelter, hotel or motel. A permanent address is not required for the application/certification process for WIC benefits. A mailing address is all that is necessary.

B. A migrant farm worker is any individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purpose of employment, a temporary abode.

C. Documentation of Income Eligibility may be difficult. Refer to Income Eligibility policy.

1. If a homeless applicant has income but not written verification, then he/she may make self-declaration of income. Document accordingly on income form and on "No Proof/Zero Income form". Refer to electronic manual/Certification Process/Eligibility/Applicants with No Proof or Zero Income policy.

2. If a homeless applicant declares no income, document circumstances which lead you to the conclusion that no income is available and proceed with certification procedure.

3. Income for instream migrant farm workers/families must be determined at least once every 12 months. Transfer VOC information that have expired will satisfy income standards if the income determination data contained is within the past 12 months.

D. Persons being served in shelters or homeless facilities may be eligible for WIC provided only the individual WIC participant and not the shelter or the non-WIC persons served by the shelter benefits from WIC. The following four conditions must be met by the facility for the person to be served: (The participant may receive WIC benefits immediately without knowing if the four conditions will be met. Applicants will be certified for up to 60 days until determination of facility is made. The professional will follow-up with the facility to determine if the facility meets the requirements.)

1. The shelter may not accrue financial or in-kind benefits from a person's participation in WIC, for instance by reducing its expenditures for food service because its residents are receiving WIC foods.

2. Food items purchased with WIC food instruments may not be used in communal feeding but rather are available exclusively to the WIC participant for whom they were issued.

3. Food instruments may not be picked up or redeemed at the vendor in Bulk for all program participants in their respective shelter.

4. The facility can place no constraints on the ability of the participant to receive the supplemental foods and nutrition education available under the WIC program.

E. Assessment of a facility will be done to determine if conditions are met by the facility to serve the homeless individual.

1. A telephone assessment will be completed by the retail coordinator to determine if the facility meets the four conditions to serve the homeless.

2. Documentation of this assessment will be maintained at the Local Agency.

3. A Letter of Understanding will be mailed to the facility to be signed. A signed copy will be kept on file in the State Office. Should the facility not meet the requirements of compliance or if compliance is not maintained, participants will be removed from the program and new applicants from the facility will not receive WIC benefits. Participants would be notified in writing at least 30 days prior to the expiration of benefits and referred to other homeless facilities which do meet the requirements.

II. Processing Standards

A. Applicants will be served according to the following time frames.

1. Special nutritional high risk applicants must be notified of their eligibility/ineligibility within 10 calendar days of the first request for program benefits, with the exception of clinic sites open only two clinic days per month. In these instances, the agency will be allowed 15 days to notify special high risk applicants. These include the following applicants:

a. Pregnant women, Priority I
b. Infants under 6 months of age, Priority I, II, IV
c. Migrant farm workers and family members who soon plan to leave the jurisdiction of the Local Agency

2. The Local Agency must make service to migrant farm worker participants a top priority and serve them on initial contact or the next scheduled clinic day.

3. All other applicants must be notified of their eligibility/ineligibility within 20 calendar days of application for program benefits.

B. Benefits from WIC will be considered a supplement to the receipt of meals for food in soup kitchens, shelters or emergency food assistance.

III. Access/Referral

A. Special arrangements will be made by the Local Agency when scheduling appointments to accommodate the special populations such as homeless and

migrant participants with hardships. (See Certification Process/Scheduling Appointments).

B. Nutrition education contact and referrals to other health services will be made as for all WIC participants and not solely curtailed because of an individual's homelessness or migrant status.

IV. Outreach

A. Annually, the State Office will provide the Local Agencies with a public announcement to publicize the following in their local newspapers and/or radio station: the availability of the WIC Program to homeless individuals; awareness of the four conditions to be met by a facility serving the homeless individual; locations of the WIC clinics; and the eligibility criteria for WIC.

B. Annually, the State Office will send notification to centers/facilities serving the homeless population to make them aware that WIC serves these persons and to make them aware of the conditions to be met by the facility for residents to be eligible for WIC.

C. Annually, the State Office will send notification to migrant offices to assure all migrants are aware of WIC and the benefits offered how to apply for benefits and to request distribution of WIC materials to workers and their families.

D. The Local Agency will provide ongoing marketing to inform homeless individuals about WIC and other Nutrition Services programs by the following:

Methods/Materials:

1. Provide promotional information to migrant offices, "soup" kitchens, homeless shelters, Department of Social Services and church benefactors in the area that are offering assistance to homeless persons, those who are known to hire instream farm workers and potential WIC eligibles.

   a. Pamphlet: WIC brochure
   b. WIC Poster

2. Offer to present an in-service to staff of homeless shelters and feeding sites and migrant offices to inform them of WIC and other Nutrition Services programs.

   a. WIC brochure

IV. Special Nutritional Needs

A. Tailoring

Food package tailoring will be done by the Health Professional with considerations being given to the special needs and problems of the individual:

1. Storage facilities will be considered.

2. Smaller amounts of the more perishable foods and larger amounts of the less perishable foods will be offered.

3. Specific education concerning use and storage of foods will be offered.

4. Infant formula will be given according to the water supply and refrigerator problems.

B. Nutrition Education

Specific education concerning use and storage of foods will be offered.

1. Where/When: Education contacts will be provided at the Local Agency during normal clinic hours. Flexibility may be allowed when enforcing late policies for certification because of lack of transportation.

2. How: Nutrition education will be offered on topics related to their special needs, for example, keeping foods safe and eating a balanced diet with minimal cooking.

V. Food Delivery

Foods would be purchased through the same Retail Food Instrument System as other participants.

MIGRANT INITIATIVE

BACKGROUND

South Dakota migrants have largely involved persons hired in areas throughout the state in activities such as sheep shearing, potato and bean picking, and corn tasseling. The Health Department is notified when an influx of migrant workers are coming into the state for general health concerns. WIC staff is then notified accordingly in preparation of serving the families immediately.

INITIATIVE

A coalition is being formed in the state involving all services available to serve the migrant population. The Dakota Association of Community Health Centers is taking the lead role in the establishment of the coalition. WIC staff is part of this coalition building and will be actively involved in the group.

Projects that have been planned are: development of fact sheet to be placed in strategic areas around the state to inform migrants traveling through South Dakota of where services are available. Trainings and workshops or educational materials are available to sensitize health workers to the migrant population. WIC will be conducting a workshop for WIC nutritionists specific to cultural issues of the migrants and other special populations.

HOMELESS TASK FORCE

BACKGROUND

An Interagency Council for the Homeless was established several years ago and continues in the state. It involves various state agencies with the purpose to coordinate homeless related activities among agencies and to make agencies aware of the others efforts.

WIC'S INVOLVEMENT

The WIC Director is a member of the Interagency Council for the Homeless. WIC provides information on eligibility of the homeless, tailoring of food packages and so forth. Pertinent information received from other state agencies are shared with local WIC Agencies for referral to homeless centers, grant monies, trainings, housing and so forth.

WELFARE REFORM INITIATIVE

BACKGROUND

South Dakota's Governor has established a priority of "Families First" initiative in the state. Coordination of state agencies, Department of Health, Department of Social Services, Department of Education and Cultural Affairs and Department of Human Services is to occur to meet the goals establishes:

1) establish a cooperative effort among a variety of agencies and organizations that provide services to families

2) provide an opportunity for individuals who work with families in South Dakota to explore the issues they see facing families

3) provide the opportunity for networking between agencies and persons who provide services to the citizens of the state.

WIC'S INVOLVEMENT

Common goals of agencies involved have been identified with several initiatives planned. WIC staff will participate in workgroups for early childhood and healthy pregnancies and children.

COORDINATED HEALTH CARE DELIVERY
ON THE PINE RIDGE INDIAN RESERVATION

BACKGROUND INFORMATION

The relationship between the Division of Health Services and the Pine Ridge Indian Reservation began in 1987 with the first WIC Clinic (Supplemental Food Program for Women, Infants and Children) held in a mobile unit located in Batesland. Today, we enjoy a relationship that has expanded into many health service areas through cooperative strategic planning among tribal members, Indian Health Service, and the Department of Health.

From humble beginning in a mobile WIC unit, furnished by Head Start, an IHS pediatrician and nutritionist were instrumental in bringing a state WIC clinic to Pine Ridge. This clinic is still functioning in space provided by the Oglala Sioux Tribe at Oglala Lakota College with additional clinics available in Pine Ridge, Kyle, Manderson, Porcupine and Wanblee.

As a result of the success of the WIC Program, establishment of Family Planning Services began in 1988 through the Maternal and Child Health Program. Family Planning Services includes provision of reproductive health education to school age students and women.

In addition, a comprehensive school health education project began in the same year, 1988, to train teachers and implement K-12 health education in public and private school districts serving reservation students.

By 1989 several staff members of the Division of Health Services realized that while many services were being provided at Pine Ridge, little coordination was taking place, thus, we were not as effective as we could be in meeting the health needs of reservation residents. In conversations with Indian Health Service staff and tribal health service providers we realized that this need for coordination was a common interest. As a result, a community health planning task was convened at Oglala Lakota college in Kyle to provide a context for more effective collaboration and communication. The task force represented many segments of the reservation community including tribal government and police, education, health, emergency medical services, and IHS.

Group members took a serious look at the Pine Ridge Reservation, identifying needs and developing their own goals for improving the health status of reservation residents. They identified goals in four broad areas -- economic development, alcohol and drug treatment, comprehensive health education, and maternal and child health.

PLANNING FOR IMPROVED SERVICES

The group met every two months from December 1989 through September 1990 at Oglala Lakota Community College. A strategic planning process was used to develop the following goals and objectives:

GOAL I: Our goal is the birth and growth of a healthy child by improving the welfare, education and health of mothers and fathers.

Objective 1: By March 1, 1991 we will have a clinic in Manderson, Wanblee and Porcupine that would include nurse midwives, pediatric nurse practitioners, WIC and Community Health Representatives and will have a system of transportation to get the clients to these clinics once a month.

GOAL II: Our goal is to develop a comprehensive school and community education program which provides child care, education and career training from birth to grave.

Objective 1: By March 1, 1991 all children in schools, K-12, will be involved in comprehensive health education curriculum that is relevant to their culture.

Objective 2: By March 1, 1991 we will establish a Day Care Center in Little Wound School.

GOAL III: Our goal is to establish a family oriented treatment facility that will provide education, intervention, treatment and after care.

Objective 1: By March 1, 1991 establish a Youth Half-Way House.

GOAL IV: Our goal is to develop the private sector, economically through an assessment of needs to provide employment and to promote health well being and to generate revenue.

Objective 1: By March 1, 1991 an OST transportation system will be in operation.

At each meeting progress reports were given and further strategies were developed to address on-going needs.

ACCOMPLISHMENTS

The greatest achievements have been made in health education and maternal and child health due to the strong community commitment to those areas. The satellite WIC clinics with their "one-stop shopping" approach to health service are the most important short term result of the project. In the area of health education, comprehensive health education is in the process of being implemented in virtually all school buildings on the reservation.

WIC Clinics:

Six clinics are held on the Pine Ridge Indian Reservation with a unique cooperative arrangement between three governmental entities, IHS, Oglala Sioux Tribe and the South Dakota Department of Health. The clinics are in Pine Ridge, Kyle, Manderson, Porcupine, Wanblee, and Batesland. One-stop shopping is accessible through the WIC clinics in conjunction with IHS for well-baby, prenatal and immunization clinics and physician services. In addition, WIC staff certifies mothers and infants for WIC services during their stay at the IHS hospital.

Funding and administration for these clinics is provided by the Department of Health, WIC Program. Indian Health Service provides funding for staff and lab services. The Oglala Sioux Tribe provides space, telephone, utilities and office equipment for the clinics. No monies are exchanged between the parties for operation of the clinics and state staff is reservation residents as much as possible.

Family Planning Coordinator:

A full-time state employee provides education to school age students and to women of reproductive age regarding issues of reproductive health. Staff provides education to women receiving prenatal and post-partum care. In addition, culturally sensitive reproductive health education is provided to students, K-12.

Services provided are in cooperation with IHS and the Oglala Sioux Tribe. IHS provides physical exams for Family Planning clients and space is provided by the Oglala Sioux Tribe, which is the same facility used as WIC. Co-location of Family Planning and WIC programs provide easy access of services and utilization of both programs.

Comprehensive School Health Education:

The comprehensive health education curriculum, "Growing Healthy" and/or Teen Health Teaching Modules, K-12, used by other school districts in the state, has been implemented on the reservation by the following schools:

- Crazy Horse
- American Horse
- Little Wound
- Wolf Creek (Shannon county schools)
- Batesland (Shannon county schools)

Indian Health Services recognized the principal and staff of Crazy Horse School for its comprehensive health education program.

The curriculum has been adapted for Lakota speaking Sioux Indian Schools. We have served as a process model for cultural adaptations for Richmond Schools, Richmond, California, World Health Organization, western bloc countries, and Arizona, IHS.

Funding for the implementation of comprehensive health education in reservation communities is made by the South Dakota Department of Health through a grant from the U.S. Department of Education.

Little Wound Day Care Center:

A grant has been funded by the Governor's Youth At Risk Trust Fund to establish a day care center for students with children at Little Wound School.

Special Community Health Representations:

Tribal Community Health Representations were assigned to do MCH work to train parents and provide education in the community.

Lactation Team:

A Lactation Team was developed between IHS and WIC to promote breastfeeding with the number of women breastfeeding significantly increasing.

In recognition of these efforts, the Governor acknowledged the Division of Health Services staff by presenting them with the Governor's Award of Employee Excellence for Teamwork. To further these efforts, the Division of Health Services prioritized staffing positions to commit a contact person designated as a Reservation Specialist statewide.

Residents of the Pine Ridge Indian Reservation have experienced an increase in the availability and accessibility of health services as a result of coordinated planning. These efforts have been very successful and can be replicated in other Indian reservations in South Dakota as well as throughout the nation.

HEALTH 2000 STRATEGIC PLAN

BACKGROUND

The South Dakota Department of Health (DOH) launched a health planning process in early 1989 called Health 2000, to improve the health of South Dakota residents. HEALTH 2000 identified and began working toward specific health objectives set for the year 2000. In 1990, Governor George S. Mickelson implemented a strategic planning initiative to direct future policy development, activities, resource allocation and staffing throughout state government. As a result, the two have been combined so that in 1992, the department has a 5-year strategic plan called "HEALTH 2000".

Implementation of the strategic plan satisfies the following aims:

a. To address South Dakota's major public health programs (especially those not being addressed) in a comprehensive way;
b. To promote strategies designed to prevent health problems rather than exhausting resources later to bring them under control;
c. To implement disease reduction strategies to improve the health of all South Dakotans, yet emphasize specifically targeted risk groups;
d. To implement and evaluate federal health strategies contained in Healthy People 2000, the national health objectives;
e. To develop resources, authorities, and new capacities to support pertinent disease prevention efforts; and,
f. To construct partnerships with other governmental, health-related and special interest groups and individuals to mutually address health problems in a multi-disciplinary, community-based fashion.

PROCESS

A strategic planning process was used to determine health needs of the state and identified priorities of health issues, which DOH pursues on an annual and long-term basis and uses as a premise for the agency's budgetary requests and legislative actions.

Goals were established which represent the primary approaches to addressing priority health needs of South Dakotans. They reflect the aims of programs, services and initiatives within the South Dakota Department of Health.

HEALTH PROMOTION AND DISEASE PREVENTION

Goal: Provide health protection from environmental health hazards.
Goal: Promote healthy lifestyles/prevent injury and chronic disease.

ACCESS TO QUALITY, AFFORDABLE HEALTH CARE

Goal: Improve financial access to essential health care services.
Goal: Improve access to essential health care services for rural and underserved populations.
Goal: Assure the quality and safety of health care services and facilities.

DELIVERY OF PUBLIC HEALTH PROGRAMS

Goal: Reduce the incidence of communicable disease.
Goal: Provide specialized services to target populations.
Goal: Provide support for public health activities.

Objectives identify specific areas of concentration and are characterized as either developmental or operational:

Developmental objectives - objectives are new department initiatives, special focus issues, or prominent problems that required better substantial reprioritization of existing staff or funds or new resources, program capacity of staff.

Operational objective - established public health activities that have existing capacities.

Workgroups consisting of DOH employees and public and private interested parties, facilitate actual implementation of the strategic plan and develop and carryout specific activities. The varied spectrum of participants promotes the development of partnerships to mutually address health problems in a multi-disciplinary, community-based fashion.

Nutrition Services Staff/WIC Staff are involved in the following workgroups in the department: Improved Pregnancy Outcomes, Immunization Initiative, Tobacco Use and Cardiovascular, and Breast Cancer.

WIC INVOLVEMENT

Developmental goals are incorporated in the DOH plan relating to WIC in the areas of improved pregnancy outcomes, and immunizations. These are:

1) Increase the number of pregnant women participating in the WIC Program

   a) MCH Program will revise prenatal newsletter subscription form to include a question regarding participation on WIC and follow-up appropriately.
   b) Promote integration and referral between WIC and DSS through distribution of WIC flyers with Food Stamps and AFDC checks and referral of Medicaid pregnant women under the Case Management of Pregnant Women Program.
   c) Increase marketing efforts through PSA's, news releases, feature stories, posters in public places, flyers in grocery stores, contact with hospitals and professionals in local communities and obstetrical personnel teaching prenatal classes, WIC flyers in maternity packets
   d) Work with IHS, Healthy Start and tribal officials to increase accessibility to WIC clinics.
   e) Expand WIC satellite clinics in highest counties on the Affirmative Action Plan.

2) Improve availability of immunizations to children under the age of two who are Women, Infants and Children (WIC) recipients.
   a) Identify regions for placement of immunization outreach workers to include professional and support personnel.
   b) Hire a WIC/Immunization Project Coordinator to research, analyze and develop a plan to review WIC charts, to identify under-immunized children and immunize or refer them for immunization.
   c) Provide access to immunizations at no or low cost to the recipient.
   d) Instruct applicants to bring their child's immunization records to WIC appointments to identify those in need of immunizations.

The State WIC Plan's goals and objectives are incorporated in the DOH Plan as operational goals annually.

Healthy People 2010

The South Dakota Department of Health has developed Department of Health 2010 Initiatives. Goals include: Improve Birth Outcomes and Health of Infants, Children and Adolescents in South Dakota; Strengthen the Health Care Delivery System in South Dakota; Improve the Health Behaviors of South Dakotans to reduce Chronic Disease (i.e. heart disease, cancer, stroke, diabetes); Advance South Dakota's Response to Emerging Public Health Threats.

AGREEMENT FOR WIC DUAL PARTICIPATION

This Dual Participation Agreement between the two agencies is to comply with Regulation 246.4 (a) (15) of the USDA-FNS WIC Regulations, South Dakota Department of Health, Division of Health and Medical Services and the Omaha/Santee WIC Program, hereby enter into an agreement for the purpose of detecting and preventing dual participation between participants of the WIC Program within the jurisdiction of the respective agencies.

1. An exchange of current participation lists between those agencies operating in the same area. On a quarterly basis, each agency will submit a copy of the master participation list to the other agency involved. The larger agency will then be responsible for the comparison check of the lists and will notify the other agency involved of any discrepancies occurring.

2. If dual participation does occur:

    a. Immediate disqualification from one of the programs for participants found in violation due to participation.
    b. Where deliberate misrepresentation is involved, the participant may be disqualified from participation in both programs. (246.12 (u) (2).
        - Warning may be given prior to the imposition of state sanction.
        - Participants may be suspended for a period not to exceed one year.
        - Suspension shall be waived for infants, children and those participating under age 18 if the State/Local Agency designates and approves a proxy, and the competent professional authority determines that a serious health risk may result from Program disqualification.
        - Participants shall be given full opportunity to appeal a suspension.

This agreement may be cancelled or terminated by mutual consent. The party desiring to terminate or cancel must give written notice of their intention thirty (30) days prior to the date of cancellation setting forth the reasons and conditions of said termination.

South Dakota Department of Health
WIC PROGRAM

_____
Rhonda Buntrock, WIC Director
Pierre, SD 57501

Date: _____

Omaha/Santee
TRIBAL WIC PROGRAM

_____
Alicia Drum, WIC Director
Macy, NE 68039

Date: _____